BlueCross BlueShield of Massachusetts

An Independent Licensee of the Blue Cross and Blue Shield Association

Please Read The Instructions Before Filling Out This Form.

Enrollment and Change Form

Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145

1. To Be Filled Out by Your Employer

Company Name				Current Medical Group #		Medical Group # Transferring To
Current BCBS ID Number, if any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Initial Eligibility Date MM DD YYYY	**Current Dental Group #**		**Dental Group # Transferring To**

Type of Transaction (Please fill in termination code, see instructions)

Add X Change X Cancel

Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)

2. Tell Us About Yourself (Member 1)

What product are you selecting? HMO Blue X | Network Blue X | Blue Choice X | Dental Blue X | HMO Blue New England X | Blue Choice New England X | PPO X | Other (write name of Plan) X ______

Kind of Membership (Medical) Individual X Family X

Kind of Membership (Dental) Individual X Family X

Your First Name	M.I.	Last Name	Sex	Date of Birth MM DD YYYY

Street Address / P.O. Box No.	Apt. No.	City/Town	State	Zip Code

Social Security No.	Home Telephone No. (include area code)	Other Insurance? * N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. X

Are you or anyone Listed Below Covered by Medicare? * Y (Y / N)	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Medicare No. ______ X 65+ X disabled X ESRD	Actively Working Y / N N Retired Y / N N If yes, date:

**** If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.***

3. Tell Us About Your Spouse (Member 2)

Spouse's First Name	M.I.	Spouse's Last Name	Sex	Date of Birth MM DD YYYY

Social Security No.	Home Telephone No. (include area code)	Other Insurance? N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. X

Part A Effective Date MM DD YYYY	**Part B Effective Date** MM DD YYYY	Medicare No. ______ X 65+ X disabled X ESRD	Actively Working Y / N N Retired Y / N N If yes, date:

4. Tell Us About Your Dependents (Members 3, 4, and 5)

Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. X
Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. X
Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. X

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use and disclosure of my information in "Our Commiment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature ______ Date ______

Employer's Signature ______ Date ______